FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042010

Facility Name: Alden Des Plaines Rehab & HC

Address: 1221 Golf Road (Number) Des Plaines (City) 60016 (Zip Code)

County: Cook

Telephone Number: (847) 768-1300 **Fax #** (847) 768-1668

IDPA ID Number: 36- 4271650

Date of Initial License for Current Owners: 10/31/2000

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven M. Kroll

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	110	Skilled (SNF)		40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS		40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,429	7,443	14,990	23,862	8
9	SNF/PED					9
10	ICF	451	646		1,097	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,880	8,089	14,990	24,959	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.16%

D. How many bed-hold days during this year were paid by Public Aid?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 10/31/00

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 10/31/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 85 and days of care provided 14,990

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	479,669	43,000		522,669	2,431	525,100		525,100			1
2	Food Purchase		254,547		254,547	(24,443)	230,104	4,589	234,693			2
3	Housekeeping	94,220	23,788		118,008	503	118,511		118,511			3
4	Laundry	41,349	23,911		65,260	109	65,369		65,369			4
5	Heat and Other Utilities			136,182	136,182		136,182	(4,244)	131,938			5
6	Maintenance	51,589		107,858	159,447	106	159,553	4,110	163,663			6
7	Other (specify):*											7
8	**TOTAL General Services**	666,827	345,246	244,040	1,256,113	(21,294)	1,234,819	4,455	1,239,274			8
	B. Health Care and Programs											
9	Medical Director			35,000	35,000		35,000		35,000			9
10	Nursing and Medical Records	1,801,069	135,759	2,640	1,939,468	5,428	1,944,896	(115,994)	1,828,902			10
10a	Therapy	69,589			69,589		69,589		69,589			10a
11	Activities	72,526	2,092	2,737	77,355		77,355		77,355			11
12	Social Services	40,061			40,061		40,061		40,061			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,983,245	137,851	40,377	2,161,473	5,428	2,166,901	(115,994)	2,050,907			16
	C. General Administration											
17	Administrative	136,856			136,856		136,856		136,856			17
18	Directors Fees											18
19	Professional Services			702,295	702,295		702,295	(668,386)	33,909			19
20	Dues, Fees, Subscriptions & Promotions			48,983	48,983	(473)	48,510	(42,187)	6,323			20
21	Clerical & General Office Expenses	387,630	22,836	52,259	462,725	818	463,543	64,967	528,510			21
22	Employee Benefits & Payroll Taxes			407,771	407,771	15,521	423,292	39,811	463,103			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,568	5,568		5,568	5,474	11,042			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			22,075	22,075		22,075	9,089	31,164			26
27	Other (specify):* Bad Debt			18,175	18,175		18,175	(18,175)				27
28	**TOTAL General Administration**	524,486	22,836	1,257,126	1,804,448	15,866	1,820,314	(609,407)	1,210,907			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,174,558	505,933	1,541,543	5,222,034		5,222,034	(720,946)	4,501,088			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Des Plaines Rehab & HC #0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation					53,640	53,640	225,947	279,587			30
31	Amortization of Pre-Op. & Org.							818	818			31
32	Interest			167,752	167,752		167,752	603,643	771,395			32
33	Real Estate Taxes							155,711	155,711			33
34	Rent-Facility & Grounds			1,175,739	1,175,739		1,175,739	(1,175,451)	288			34
35	Rent-Equipment & Vehicles			12,988	12,988		12,988	8,145	21,133			35
36	Other (specify):* mortgage insurance			53,640	53,640	(53,640)		51,700	51,700			36
37	**TOTAL Ownership**			1,410,119	1,410,119		1,410,119	(129,487)	1,280,632			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	20,506	777,085	1,053,724	1,851,315		1,851,315	(434,315)	1,417,000			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		2,638		2,638		2,638	(2,638)				41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	20,506	779,723	1,113,949	1,914,178		1,914,178	(436,953)	1,477,225			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,195,064	1,285,656	4,065,611	8,546,331		8,546,331	(1,287,386)	7,258,945			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(90,930)	30		9
10	Interest and Other Investment Income	(39,096)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(325)	2		13
14	Non-Care Related Interest	(128,400)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(486)	32		18
19	Entertainment	(1,539)	20		19
20	Contributions	(1,225)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,175)	27		24
25	Fund Raising, Advertising and Promotional	(23,591)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (303,767)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(931,216)		34
35	Other- Attach Schedule	(41,482)	pg 5a	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (972,698)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,276,465)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Des Plaines Rehab & HC

ID# 0042010

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BACK OUT: HEALTHCARE ASSOC PAC FEES	$ (455)	20	1
2	BACK OUT:CLOTHING /GIFT SHOP ITEMS	(2,638)	41	2
3	LEGAL FEES-COLLECTIONS	(2,755)	21	3
4	BACK OUT MARKETING MGT FEE	(13,047)	20	4
5	BACK OUT MARKETING CONSULTANT	(2,514)	20	5
6	Back out utility late fee	(5,812)	5	6
7	back out marketing salary	(14,261)	21	7
8	back out prior yr deprec exp (adj to correct '01)	(10,921)	30	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(52,403)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(325)	0	0	4,914	0	0	0	0	0	0	0	4,589	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,812)	0	1,568	0	0	0	0	0	0	0	0	(4,244)	5
6	Maintenance	0	0	4,176	0	0	0	(66)	0	0	0	0	4,110	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,137)	0	5,744	4,914	0	0	(66)	0	0	0	0	4,455	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(113,066)	(2,928)	0	0	0	0	0	0	(115,994)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(113,066)	(2,928)	0	0	0	0	0	0	(115,994)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(3,492)	(664,894)	0	0	0	0	0	0	0	0	(668,386)	19
20	Fees, Subscriptions & Promotions	(42,371)	0	184	0	0	0	0	0	0	0	0	(42,187)	20
21	Clerical & General Office Expenses	(17,016)	0	11,419	52,783	17,781	0	0	0	0	0	0	64,967	21
22	Employee Benefits & Payroll Taxes	0	0	36,981	0	2,830	0	0	0	0	0	0	39,811	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,474	0	0	0	0	0	0	0	0	5,474	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	9,089	0	0	0	0	0	0	0	0	0	9,089	26
27	Other (specify):*	(18,175)	0	0	0	0	0	0	0	0	0	0	(18,175)	27
28	**TOTAL General Administration**	(77,562)	5,597	(610,836)	52,783	20,611	0	0	0	0	0	0	(609,407)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(83,699)	5,597	(605,092)	(55,369)	17,683	0	(66)	0	0	0	0	(720,946)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(101,851)	311,477	12,564	0	3,757	0	0	0	0	0	0	225,947	30
31	Amortization of Pre-Op. & Org.	0	0	685	0	0	133	0	0	0	0	0	818	31
32	Interest	(167,982)	745,448	21,374	0	2,961	1,842	0	0	0	0	0	603,643	32
33	Real Estate Taxes	0	152,958	1,835	0	918	0	0	0	0	0	0	155,711	33
34	Rent-Facility & Grounds	0	(1,175,739)	288	0	0	0	0	0	0	0	0	(1,175,451)	34
35	Rent-Equipment & Vehicles	0	0	8,145	0	0	0	0	0	0	0	0	8,145	35
36	Other (specify):*	0	51,700	0	0	0	0	0	0	0	0	0	51,700	36
37	**TOTAL Ownership**	(269,833)	85,844	44,891	0	7,636	1,975	0	0	0	0	0	(129,487)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(52,241)	(116,022)	(266,052)	0	0	0	0	0	(434,315)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(2,638)	0	0	0	0	0	0	0	0	0	0	(2,638)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(2,638)	0	0	(52,241)	(116,022)	(266,052)	0	0	0	0	0	(436,953)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(356,170)	91,441	(560,201)	(107,610)	(90,703)	(264,077)	(66)	0	0	0	0	(1,287,386)	45

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See page 6k		See page 6k		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,175,739	Alden-Des Plaines Rehab. And Health Care Center, LLC	100.00%	$	$ (1,175,739)	1
2	V	32	Investments - RR	646	Alden-Des Plaines Rehab. And Health Care Center, LLC			(646)	2
3	V	19	Misc. income	8,829	Alden-Des Plaines Rehab. And Health Care Center, LLC			(8,829)	3
4	V	19	Accounting		Alden-Des Plaines Rehab. And Health Care Center, LLC		3,700	3,700	4
5	V	19	Misc. expense		Alden-Des Plaines Rehab. And Health Care Center, LLC		1,637	1,637	5
6	V	33	Real estate taxes		Alden-Des Plaines Rehab. And Health Care Center, LLC		152,958	152,958	6
7	V	26	Property & liability insurance		Alden-Des Plaines Rehab. And Health Care Center, LLC		9,089	9,089	7
8	V	32	Interest on mortgage payable		Alden-Des Plaines Rehab. And Health Care Center, LLC		746,094	746,094	8
9	V	36	Mortgage insurance premium		Alden-Des Plaines Rehab. And Health Care Center, LLC		51,700	51,700	9
10	V	30	Depreciation		Alden-Des Plaines Rehab. And Health Care Center, LLC		311,477	311,477	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,185,214			$ 1,276,655	$ * 91,441	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	employee benefits	$	Alden Management Services	0.00%	$ 36,981	$ 36,981	15
16	V	19	profess. Fees	669,935	Alden Management Services		5,041	(664,894)	16
17	V	21	g & a		Alden Management Services		11,419	11,419	17
18	V	5	utilities		Alden Management Services		1,568	1,568	18
19	V	6	maintenance		Alden Management Services		4,176	4,176	19
20	V	24	auto/travel		Alden Management Services		5,474	5,474	20
21	V	20	subscriptions/etc		Alden Management Services		184	184	21
22	V	30	depreciation		Alden Management Services		12,564	12,564	22
23	V	31	amortization		Alden Management Services		685	685	23
24	V	33	real estate tax		Alden Management Services		1,835	1,835	24
25	V	34	rent		Alden Management Services		288	288	25
26	V	35	rent-equip/vehicles		Alden Management Services		8,145	8,145	26
27	V	32	interest		Alden Management Services		21,374	21,374	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 669,935			$ 109,734	$ * (560,201)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Tube feeding	$	Pyramid Health Care Services	100.00%	$ 4,914	$ 4,914	15
16	V	10	Nursing supplies	122,713	Pyramid Health Care Services		9,647	(113,066)	16
17	V	39	Per diem/other supplies	127,416	Pyramid Health Care Services		75,175	(52,241)	17
18	V	21	General & admin		Pyramid Health Care Services		52,783	52,783	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 250,129			$ 142,519	$ * (107,610)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	$ 278,095	Forum Extended Care II	100.00%	$ 213,197	$ (64,898)	15
16	V	10	House stock	12,548	Forum Extended Care II		9,620	(2,928)	16
17	V	39	IV	219,073	Forum Extended Care II		167,949	(51,124)	17
18	V	22	Employee benefits		Forum Extended Care II		2,830	2,830	18
19	V	21	G & A		Forum Extended Care II		17,781	17,781	19
20	V	32	Interest		Forum Extended Care II		2,961	2,961	20
21	V	33	Real estate taxes		Forum Extended Care II		918	918	21
22	V	30	Depreciation		Forum Extended Care II		3,757	3,757	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 509,716			$ 419,013	$ * (90,703)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 1,033,692	Community Physical Therapy	100.00%	$ 767,640	$ (266,052)	15
16	V	32	Interest		Community Physical Therapy		1,842	1,842	16
17	V	31	Amortization		Community Physical Therapy		133	133	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,033,692			$ 769,615	$ * (264,077)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance expense	$ 22,354	Alden Bennett Construction	100.00%	$ 22,288	$ (66)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 22,354			$ 22,288	$ * (66)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Floyd Schlossberg a.	President	Chief Executive		354,448	0.964	2.41	SALARY	$ 8,764	17-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.		89,499	0.964	2.41	SALARY	2,213	17-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten		83,745	0.964	2.41	SALARY	2,071	17-1	3
4	Joan Carl d.	Secretary	Vice-President		215,753	0.964	2.41	SALARY	5,335	17-1	4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	$ 18,383		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8A (also on page 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge		X	Mortgage	$66,537.00	8/31/00	$ 10,390,300	$ 10,338,257	6/30/2040	7.2000	$ 746,094	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Related Party - AMS	X		Working capital							21,374	6
7	Related Party - FECII	X		Working capital							2,961	7
8	Related party - CPT	X		Working capital							1,842	8
9	TOTAL Facility Related				$66,537.00		$ 10,390,300	$ 10,338,257			$ 772,271	9
	B. Non-Facility Related*											
10	offset interest expense with interest income on DsP I, LLC's books										(646)	10
11	offset interest expense with interest income on Corp's books										(230)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (876)	14
15	TOTALS (line 9+line14)						$ 10,390,300	$ 10,338,257			$ 771,395	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 51,700 Line # 36**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 150,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 112,958	2
3. Under or (over) accrual (line 2 minus line 1).		$ (37,042)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 190,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 152,958	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999	11,326	10
2000	5,663	11
2001	112,958	12

Accrual based on 68% increase over prior year bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Des Plaines Rehab & HC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042010

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-586-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-17-200-0128-0000	Nursing home facility	$ 69,491.05	$ 69,491.05
2.	09-17-200-129-0000	Nursing home facility	$ 43,466.48	$ 43,466.48
3.		Related Party - Alden Management	$ 76,052.00	$ 1,835.00
4.		Related Party - Forum	$ 8,608.00	$ 918.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 197,617.53	$ 115,710.53

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,490 B. General Construction Type: Exterior brick Frame steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing home	51,490	2000	$ 1,016,045	1
2					2
3	TOTALS	51,490		$ 1,016,045	3

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 18,359	$	22	$	$	$ 18,359	4
5											5
6	110		2000	2000	6,986,060	242,149	40	174,657	(67,492)	461,271	6
7											7
8											8
	Improvement Type**										
9	ISS/Chicago Sound & Communication(vent alarm interface)			2000	3,400	340	10	340		907	9
10	Alden Bennett Construction(multiple wireless install)			2001	4,894	489	10	489		816	10
11	Owners extras			2000	524,876	26,244	20	26,244		63,423	11
12	Owners extras			2000	12,972	649	20	649		1,568	12
13	description to follow			2002	13,921						13
14	description to follow			2002	1,076						14
15	description to follow			2002	1,646						15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,567,204	$ 269,871		$ 202,379	$ (67,492)	$ 546,343	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,567,204	$ 269,871		$ 202,379	$ (67,492)	$ 546,343	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	19,335		20			19,334	4
5	Leasehold Improvement-Remodeling	1980	1,208		10			1,208	5
6	Leasehold Improvement-Remodeling	1986	645		5			645	6
7	Leasehold Improvement-Remodeling	1990	404		5			404	7
8	Leasehold Improvement-Remodeling	1991	94		5			94	8
9	Leasehold Improvement-Remodeling	1993	8,304	830	10	830		8,304	9
10	Leasehold Improvement-Remodeling	1993	6,504	469	9.7	469		6,504	10
11	Leasehold Improvement-sign	1994	261	22	12	22		174	11
12	Leasehold Improvement-dryvit	1995	443	44	10	44		310	12
13	Leasehold Improvement-new ac	1999	723	48	15	48		145	13
14	Leasehold Improvement-roof	1985	972	52	19	52		922	14
15	Leasehold Improvement-roof	1994	863	58	15	58		518	15
16	Leasehold Improvement-roof	1997	819	55	15	55		328	16
17	Leasehold Improvement-roof	1998	1,390	93	15	93		464	17
18	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11		33	18
19	Leasehold Improvement-hallway lighting	2001	155	16	10	16		32	19
20	Leasehold Improvement-DAI	2001	195	19	10	19		38	20
21	Leasehold Improvement-bathrooms	2002	687	69	10	69		69	21
22	Leasehold Improvement-Remodeling	2002	98	20	5	20		20	22
23	Related Party-AMS:								23
24	Leasehold Improvement-Remodeling	1993	4,266		7			4,266	24
25	Leasehold Improvement-Remodeling	1994	2,112		7			2,112	25
26	Leasehold Improvement-Remodeling	2002	5,221		7				26
27									27
28									28
29									29
30									30
31									31
32	Related Party-Forum Ext. Care	1999	1,764	676	40	676		183	32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,623,778	$ 272,353		$ 204,861	$ (67,492)	$ 592,450	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 580,125	$ 82,879	$ 59,441	$ (23,438)	VARIOUS	$ 203,325	71
72	Current Year Purchases	58,046	840	840		VARIOUS	840	72
73	Fully Depreciated Assets	39,228	688	688		VARIOUS	39,228	73
74								74
75	TOTALS	$ 677,399	$ 84,407	$ 60,969	$ (23,438)		$ 243,392	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	CAR ENGINE/BUS/VAN	:DODGE	98-'02	$ 12,336	$ 3,792	$ 3,792	$	3	$ 9,992	76
77	bus	'01	'01	49,826	9,965	9,965		3	19,930	77
78										78
79										79
80	TOTALS			$ 62,162	$ 13,757	$ 13,757	$		$ 29,922	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,379,384	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 370,517	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 279,587	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (90,930)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 865,765	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	n/a	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ n/a	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease: related party- cost is backed out.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning 10/1/00
    Ending open

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ varies-
13.	/2004	$ triple net lease
14.	/2005	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO
16. Rental Amount for movable equipment: $ 12,988 Description: copy machine lease
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	various	various	$ 678.75	$ 8,145	17
18					18
19					19
20					20
21	TOTAL		$ 678.75	$ 8,145	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Skilled nurses on sight

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 339,983	$		$ 339,983	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			91,939			91,939	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			601,207			601,207	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see page 16a	# of prescrpts				171,878		171,878	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program			20,506					20,506	12
13	Other (specify):	see page 16a					191,487		191,487	13
14	TOTAL			$ 20,506		$ 1,033,129	$ 363,365		$ 1,417,000	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden Des Plaines Rehab & HC **#** 0042010 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 15,697	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 40,000)	1,686,647	1,687,767	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		299,754	5
6	Prepaid Insurance	1,376	1,376	6
7	Other Prepaid Expenses	3,902	40,457	7
8	Accounts Receivable (owners or related parties)	468,440	2,281,655	8
9	Other(specify): Due from IDPA	25,837	25,837	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,186,202	$ 4,352,543	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,003,985	13
14	Buildings, at Historical Cost		9,685,956	14
15	Leasehold Improvements, at Historical Cost	565,849	1,605,766	15
16	Equipment, at Historical Cost	167,815	167,815	16
17	Accumulated Depreciation (book methods)	(110,365)	(837,664)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe automobiles	49,826	49,826	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 673,124	$ 11,675,683	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,859,326	$ 16,028,226	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,174,682	$ 1,198,782	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,976	59,976	28
29	Short-Term Notes Payable		55,916	29
30	Accrued Salaries Payable	199,171	199,171	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,842	17,842	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	298,866	360,896	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due from BCBS & accrued other exp.	478,348	680,163	36
37	Due to affiliates	1,498,292	3,289,745	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,727,176	$ 5,862,490	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		10,282,341	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to stockholders	1,284,000	1,284,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,284,000	$ 11,566,341	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,011,176	$ 17,428,831	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,151,850)	$ (1,400,605)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,859,326	$ 16,028,226	48

***(See instructions.)**

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,826,881)	1
2	Restatements (describe):		2
3	**External auditor's adjustments made after 2001 cost**		3
4	**report was submitted. These adj's have no effect on costs**	(9,708)	4
5	**(bad debt expense, non-allowable, and medicare revenue)**		5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,836,589)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(315,261)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (315,261)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,151,850)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,842,633	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,842,633	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	72,973	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 72,973	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. income	678	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 678	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,916,284	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,256,113	31
32	Health Care	2,161,473	32
33	General Administration	1,804,448	33
	B. Capital Expense		
34	Ownership	1,410,119	34
	C. Ancillary Expense		
35	Special Cost Centers	1,853,953	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37	Related party salary allocations	(314,786)	37
38	Back out non-facility expenses for DesPlaines II in pg 3&4.		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,231,545	40
41	**Income before Income Taxes (line 30 minus line 40)****	(315,261)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (315,261)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,088	2,261	$ 70,284	$ 31.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,807	30,787	870,757	28.28	3
4	Licensed Practical Nurses	4,460	4,669	100,739	21.58	4
5	Nurse Aides & Orderlies	53,937	55,605	714,429	12.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,019	2,160	36,780	17.03	9
10	Activity Assistants	3,372	3,507	35,746	10.19	10
11	Social Service Workers	1,987	2,083	40,061	19.23	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,089	59,671	28.56	13
14	Head Cook	5,048	5,477	84,670	15.46	14
15	Cook Helpers/Assistants	35,770	36,716	335,328	9.13	15
16	Dishwashers					16
17	Maintenance Workers	1,908	1,950	43,319	22.21	17
18	Housekeepers	10,509	10,903	94,220	8.64	18
19	Laundry	4,807	5,037	41,349	8.21	19
20	Administrator					20
21	Assistant Administrator	1,631	1,805	61,581	34.12	21
22	Other Administrative	7,424	7,811	142,367	18.23	22
23	Office Manager					23
24	Clerical	4,661	4,763	58,395	12.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,881	2,053	56,678	27.61	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	405	405	8,649	21.36	31
32	Other Health C: Alzheimers	4	4	40	10.00	32
33	Other(specify) Clincal SS	861	880	25,215	28.65	33
34	TOTAL (lines 1 - 33)	174,523	180,965	$ 2,880,278 *	$ 15.92	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	35,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,640	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	39	2,077	11-3	44
45	Social Service Consultant	13	660	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	52	$ 40,377		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Berman,J	administrator		50,000
Rosete,M	administrator		40,611
Weber, K/Gottesman	administrator		10,317
various executives/assist admin	executive admin		35,928
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,856

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Alden Management Service	management fees	669,935
BDO Seidman	accounting fees	6,090
Kenneth J. Fisch	legal fees	25,045
Medi. Com	billing consultants	325
U.S. Gas & Energy	utility consultants	900
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 702,295

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,337
Unemployment Compensation Insurance	33,909
FICA Taxes	236,348
Employee Health Insurance	31,155
Employee Meals	24,443
Illinois Municipal Retirement Fund (IMRF)*	
Related party - FECII	2,830
Union Health & Welfare	46,298
Dental Insurance	205
Pension	5,617
Life insurance	284
Emp background checks, vacc & misc. costs	7,697
related party - Ams	36,981
TOTAL (agree to Schedule V, line 22, col.8)	$ 463,103

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Surety Bond Fees	267
Dues & Subscriptions-IHCA	5,872
related party - Ams	184
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,323

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Glenwood Auto Service	340
Amoco / State Farm	3,518
related party - Ams	5,474
Seminar Expense	
Illinois Health Care Association	910
Life Service Network	300
Comprehensive Therapeutics	500
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,042

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	hvac compressor	1/2002	$ 3,063	3	$	$	$	$ 1,021	$ 1,021	$ 1,021	$ 0	$ 0	$ 0
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,063		$	$	$	$ 1,021	$ 1,021	$ 1,021	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? yes

(2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. IL HEALTH CARE ASSOC $5872

(3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 23,114 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 60,225
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 24,443 Has any meal income been offset against related costs? NO Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? n/a
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ n/a

(17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.